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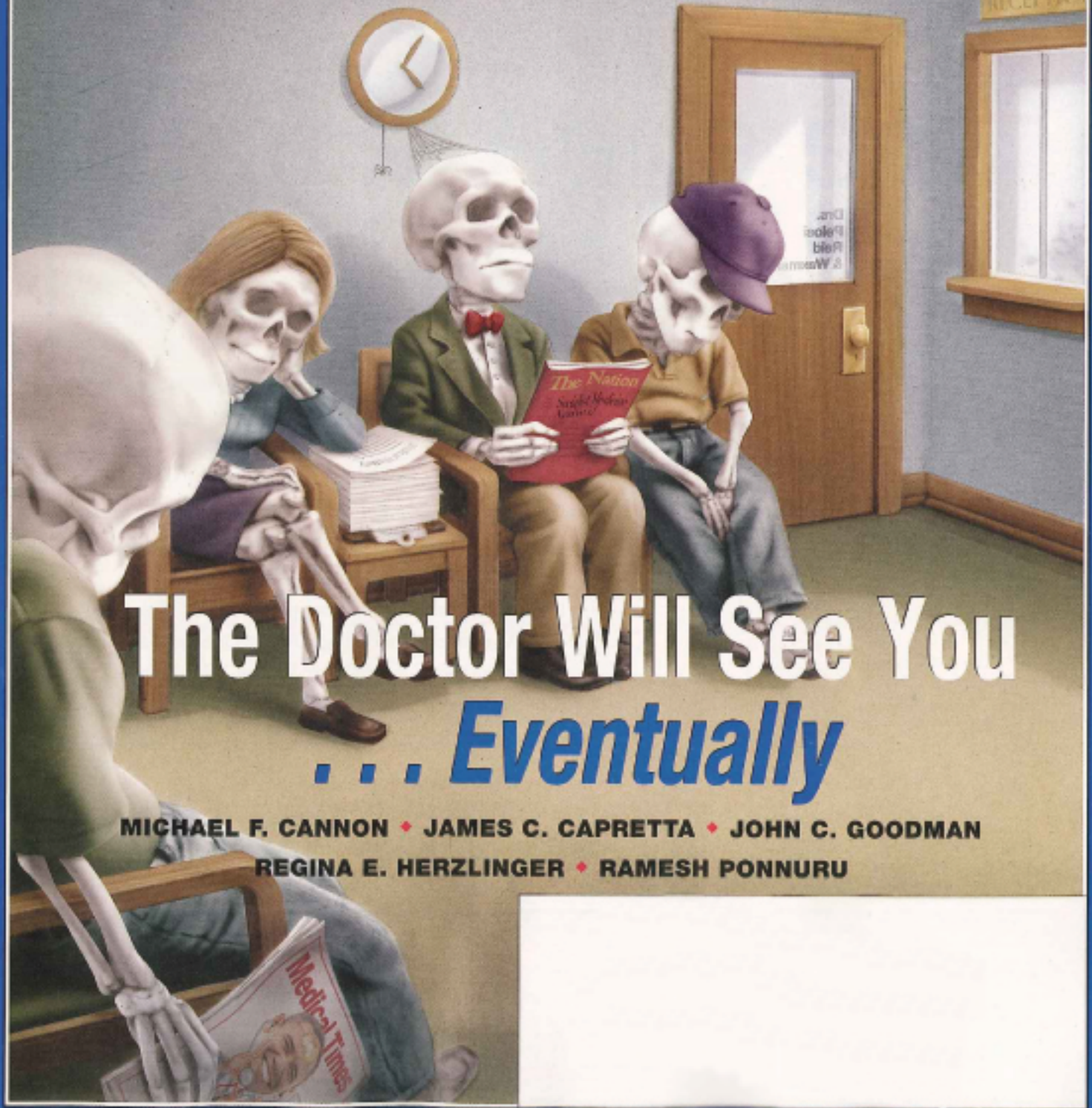

The Doctor Will See You . . . Eventually

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Socialized Failure

Dissecting health-care data from Britain, Canada, and elsewhere

BY JOHN C. GOODMAN

THE health-care systems of all developed countries face three unrelenting problems: rising costs, inadequate quality, and incomplete access to care. A slew of recent articles, published mainly in medical journals, suggest that the health-care systems of other countries are superior to ours on all these fronts. Yet the articles are at odds with a substantial economic literature.

What follows is a brief review of the evidence. As other writers demonstrate elsewhere in this issue, the American health-care system has plenty of problems. But it is not inferior to other developed countries' systems—and we should therefore not be looking to these systems, most of which are characterized by heavy government intervention, for inspiration.

Does the U.S. Spend More on Health Care?

Taken at face value, international statistics show that the United States spends more than twice as much per person on health care as the average developed country. But these statistics are misleading. Other countries are far more aggressive than we are at disguising and shifting costs—for example, by using the power of government purchase to artificially suppress the incomes of doctors, nurses, and hospital personnel. This makes their aggregate outlays look smaller when all that has really happened is that part of the cost has been shifted from one group (patients and taxpayers) to another (health-care providers). This is equivalent to taxing doctors, nurses, or some other group so that others may pay less for their care.

Normal market forces have been so suppressed throughout the developed world that the prices paid for medical services rarely reflect the services' actual cost. As a result, adding all these prices together produces aggregate numbers in which one can have little confidence. One gets a better measure of how much countries spend by looking at the real resources used; and by that measure, the U.S. system is pretty good. For example, we use fewer doctors than the average developed country to produce the same or better outcomes. We also use fewer nurses and fewer hospital beds, make fewer physician visits, and spend fewer days in the hospital. About the only thing we use more of is technology. (See below.)

Spending *totals* aside, the U.S. has been neither worse nor better than the rest of the developed world at controlling spending *growth*. The average annual rate of growth of real per capita U.S. health-care spending is slightly below the OECD average over the past four decades (4.4 percent versus 4.5 percent). It appears that other developed countries are traveling down the same spending path we are.

Are U.S. Health Outcomes Worse?

Critics point to the fact that U.S. life expectancy is in the middle of the pack among developed countries, and that our infant-mortality rate is among the highest. But are these the right measures? Within the U.S., life expectancy at birth varies greatly between racial and ethnic groups, from state to state, and across counties. These differences are thought to reflect such lifestyle choices as diet, exercise, and smoking. Infant mortality varies by a factor of two or three across racial and ethnic lines, and from city to city and state to state, for reasons apparently having little to do with health care.

All too often, the heterogeneous population of the United States is compared with the homogeneous populations of European countries. A state such as Utah compares favorably with almost any developed country. Texas, with its high minority population, tends to compare unfavorably. But these outcomes have almost nothing to do with the doctors and hospitals in the two states.

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It makes far more sense to look at the diseases and conditions to which we know medical science can make a real difference—cancer, diabetes, and hypertension, for example. The largest international study to date found that the five-year survival rate for all types of cancer among both men and women was higher in the U.S. than in Europe. There is a steeper increase in blood pressure with advancing age in Europe, and a 60 percent higher prevalence of hypertension. The aggressive treatment offered to U.S. cardiac patients apparently improves survival and functioning relative to that of Canadian patients. Fewer health- and disability-related problems occur among U.S. spinal-cord-injury patients than among Canadian and British patients.

Do Patients in Other Countries Have Better Access to Care?

Britain has only one-fourth as many CT scanners per capita as the U.S., and one-third as many MRI scanners. The rate at which the British provide coronary-bypass surgery or angioplasty to heart patients is only one-fourth the U.S. rate, and hip replacements are only two-thirds the U.S. rate. The rate for treating kidney failure (dialysis or transplant) is five times higher in the U.S. for patients between the ages of 45 and 84, and nine times higher for patients 85 years or older.

Overall, nearly 1.8 million Britons are waiting for hospital or outpatient treatments at any given time. In 2002–2004, dialysis patients waited an average of 16 days for permanent blood-vessel access in the U.S., 20 days in Europe, and 62 days in Canada. In 2000, Norwegian patients waited an average of 133 days for hip replacement, 63 days for cataract surgery, 160 days for a knee replacement, and 46 days for bypass surgery after being approved for treatment. Short waits for cataract surgery produce better outcomes, prompt coronary-artery bypass reduces mortality, and rapid hip replacement reduces disability and death. Studies show that only 5 percent of Americans wait more than four months for surgery, compared with 23 percent of Australians, 26 percent of New Zealanders, 27 percent of Canadians, and 36 percent of Britons.

Do Other Countries Do a Better Job of Delivering Preventive Care?

If people have to pay for care directly, it is often claimed, they will be inclined to skimp on preventive care—care that can catch diseases in their early stages, saving lives and money. Yet the proportion of middle-aged Canadian women who have never had a mammogram is twice that of the U.S., and three times as many Canadian women have never had a Pap smear. Fewer than a fifth of Canadian men have ever been tested for prostate-specific antigen, compared with about half of American men. Only one in ten adult Canadians has had a colonoscopy, compared with about a third of adult Americans.

These differences in screening may partly explain why the mortality rate in Canada is 25 percent higher for breast cancer, 18 percent higher for prostate cancer, and 13 percent higher for colorectal cancer. In addition, while half of all diabetics have high blood pressure, it is controlled in 36 percent of U.S. cases, compared with only 9 percent of cases in Canada.

Do the Uninsured in the U.S. Lack Access to Health Care?

Of the 46 million nominally uninsured, about 12 million are eligible for such public programs as Medicaid and the State Children's Health Insurance Program (S-CHIP). They can usually enroll even at the time of treatment, arguably making them de facto insured. About 17 million of the uninsured are living in households with annual incomes of at least $50,000. More than half of those earn more than $75,000, suggesting that they are uninsured by choice.

Like unemployment, uninsurance is usually transitory: 75 percent of uninsured spells last one year or less, and 91 percent last two years or less. Although the fraction of the population with health insurance rises and falls with the business cycle, it has been fairly constant for the past two decades, despite an unprecedented influx of immigrants with an uninsurance rate 2.5 times that of the native-born population. Guaranteed-issue laws, state high-risk pools, and retroactive Medicaid eligibility make it increasingly easy to obtain insurance after becoming ill.

Are Low-Income Families More Disadvantaged in the U.S. System?

Aneurin Bevan, father of the British National Health Service (NHS), declared, "The essence of a satisfactory health service is that rich and poor are treated alike, that poverty is not a disability and wealth is not advantaged." More than 30 years after the NHS's founding, an official task force found little evidence that it had equalized health-care access. Another study, 20 years later, concluded that access had become more unequal in the years between the two studies.

In Canada, the wealthy and powerful have significantly greater access to medical specialists than do the less well-connected poor. High-profile patients enjoy more frequent services, shorter waiting times, and greater choice of specialists. Moreover, non-elderly, white, low-income Canadians are 22 percent more likely to be in poor health than their U.S. counterparts.

In developed countries generally, among people with similar health conditions, high earners use the system more intensely, and use costlier services, than do low earners. It seems likely that the personal characteristics that ensure success in a market economy also enhance success in bureaucratic systems. **NR**

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